General Notice

COBRA Continuation Coverage Election Notice

(September 1, 2008 - February 28, 2010)

February 16, 2010

Dear *qualified beneficiary(ies),*

This notice contains important information about your right to continue your health care coverage in the Hawaii Employer-Union Health Benefits Trust Fund's (EUTF) group health plan(s) (the Plan).

Please read the information contained in this notice very carefully. The pronouns "you" and "your" refer to each of the individuals identified on the Continuation Coverage (COBRA) Election Form (Election Form) included with this General Notice.

The American Recovery and Reinvestment Act of 2009 (ARRA), as amended by the Department of Defense Appropriations Act, 2010, reduces the COBRA premium in some cases. You are receiving this election notice because you experienced a qualifying event that occurred during the period that begins with September 1, 2008 and ends with February 28, 2010 and you may be eligible for the temporary premium reduction for up to 15 months. To help determine whether you can get the ARRA premium reduction, you should read this notice and the attached documents carefully. In particular, reference the "Summary of the COBRA Premium Reduction Provisions under ARRA, as Amended" with details regarding eligibility, restrictions, and obligations and the "Application for Treatment as an Assistance Eligible Individual." **If you believe you meet the criteria for the premium reduction, complete the "Application for Treatment as an Assistance Eligible Individual" and return it with your completed Election Form.**

To elect COBRA continuation coverage, follow the instructions on the following pages to complete the enclosed Election Form and promptly submit it to us.

If you do not elect COBRA continuation coverage, your coverage under the Plan will end as noted based on the event described.

Each person ("qualified beneficiary") listed on the Election Form is entitled to elect COBRA continuation coverage, which will continue group health care coverage under the Plan until the date noted on the Election Notice. The qualified beneficiary(ies) listed on the Election Form are the only persons eligible to enroll in COBRA Continuation Coverage.

If elected, COBRA continuation coverage will begin retroactively and can last until up to 18 months after the qualifying event date shown on your Election Form.

COBRA continuation coverage costs will be based on your plan selections and the type of coverage you choose. You are eligible to enroll only in those plans listed on your Election Form. If you qualify as an "Assistance Eligible Individual" this cost can be reduced to 35% of the cost of the plan premiums you select for up to 15 months. Please do not send payment with the Election Form. You will receive instructions directly from insurance carriers with payment requirements. Carrier invoicing will be administered separately. Important additional information about payment for COBRA continuation coverage is included in the pages following the Election Form.

If you have any questions about this notice or your rights to COBRA continuation coverage, you may contact the Hawaii Employer-Union Health Benefits Trust Fund (EUTF):

by mail:
Hawaii Employer-Union Health Benefits Trust Fund (EUTF)
Attn: COBRA section
P. O. Box 2121
Honolulu, Hawaii 96805-2121

by telephone:
(808) 586-7390
Toll Free 1 (800) 295-0089

Summary of the COBRA Premium Reduction Provisions under ARRA, as Amended

President Obama signed the American Recovery and Reinvestment Act (ARRA) on February 17, 2009. On December 19, 2009, the President signed the Department of Defense Appropriations Act, 2010. These laws give "Assistance Eligible Individuals" the right to pay reduced COBRA premiums for periods of coverage beginning on or after February 17, 2009 and can last up to 15 months.

To be considered an "Assistance Eligible Individual" and get reduced premiums you:

- **MUST** have a continuation coverage election opportunity related to an involuntary termination of employment that occurred at any time from September 1, 2008 through February 28, 2010;
- **MUST** elect the coverage;
- **MUST NOT** be eligible for Medicare; AND
- **MUST NOT** be eligible for coverage under any other group health plan, such as a plan sponsored by a successor employer or a spouse's employer.*

Individuals whose nine month premium reduction ended also have an opportunity to make a payment to continue coverage at the reduced rates. These payments must be made by the later of February 17, 2010, 30 days from the date notice regarding the ARRA amendment that extended the premium reduction to 15 months was provided, or the end of the otherwise applicable payment grace period.

♦ IMPORTANT ♦

- ◊ If, after you elect COBRA and while you are paying the reduced premium, you become eligible for other group health plan coverage or Medicare you MUST notify the plan in writing. If you do not, you may be subject to a tax penalty.
- ◊ Electing the premium reduction disqualifies you for the Health Coverage Tax Credit. If you are eligible for the Health Coverage Tax Credit, which could be more valuable than the premium reduction, you will have received a notification from the IRS.
- ◊ The amount of the premium reduction is recaptured for certain high income individuals. If the amount you earn for the year is more than $125,000 (or $250,000 for married couples filing a joint Federal income tax return) all or part of the premium reduction may be recaptured by an increase in your income tax liability for the year. If you think that your income may exceed the amounts above, you may wish to consider waiving your right to the premium reduction. For more information, consult your tax preparer or visit the IRS webpage on ARRA at www.irs.gov.

For general information regarding EUTF's COBRA coverage, for specific information related to the EUTF's administration of the ARRA Premium Reduction, or to notify the plan of your ineligibility to continue paying reduced premiums, contact the EUTF at (808) 586-7390 or Toll Free at 1 (800) 295-0089 for assistance.

If you are denied treatment as an "Assistance Eligible Individual" you may have the right to have the denial reviewed. For more information regarding reviews or for general information about the ARRA Premium Reduction go to:

www.dol.gov/COBRA or call 1-866-444-EBSA (3272)

* Generally, this does not include coverage for only dental, vision, counseling, or referral services; coverage under a health flexible spending arrangement; or treatment that is furnished in an on-site medical facility maintained by the employer.

(updated February 2010)

COBRA Continuation Coverage Election Form Instructions

Instructions:

To elect COBRA continuation coverage, complete the Election Form. Remember to sign and date it prior to mailing to us. Under Federal law, you have 60 days after the date of this notice to decide whether you want to elect COBRA continuation coverage under the Plan.

Send completed Election Form to: Hawaii Employer-Union Health Benefits Trust Fund (EUTF)
Attn: COBRA section, P. O. Box 2121, Honolulu, Hawaii 96805-2121

This Election Form must be completed and returned by mail. It must be post-marked no later than 60 calendar days after the mailing date on this communication.

If you do not submit a completed Election Form by the due date referenced, you will lose your right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you furnish a completed Election Form before the due date. However, if you change your mind after first rejecting COBRA continuation coverage, your COBRA continuation coverage will begin on the date you furnish the completed Election Form.

The following are not acceptable as COBRA elections and will not preserve your COBRA continuation coverage rights: oral communications regarding COBRA coverage, including in-person or telephone statements about an individual's desire to elect COBRA; and electronic or email communications.

Read the important information about your rights and responsibilities included in the pages after the Election Form.

Specific Instructions about your COBRA Continuation Coverage Election Notice and Continuation Coverage (COBRA) Election Form:

Notification Date – The original notification date has been stricken and replaced with **February 17, 2010**.
Reply Deadline – The original reply deadline has been stricken and replaced with **April 17, 2010**.

NOTE: Dates may vary depending on the actual packet mailing date.

Important Information About Your COBRA Continuation Coverage Rights

What is continuation coverage?

Federal law requires that most group health plans (including this Plan) give employees and their families the opportunity to continue their health care coverage when there is a "qualifying event" that would result in a loss of coverage under an employer's plan. Depending on the type of qualifying event, "qualified beneficiaries" can include the employee (or retired employee) covered under the group health plan, the covered employee's spouse, and the dependent children of the covered employee.

Continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan.

How long will continuation coverage last?

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage generally may be continued only for up to a total of 18 months. In the case of losses of coverage due to an employee's death, divorce or legal separation, the employee's becoming entitled to Medicare benefits or a dependent child ceasing to be a dependent under the terms of the plan, coverage may be continued for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. This notice shows the maximum period of continuation coverage available to the qualified beneficiaries.

Continuation coverage will be terminated before the end of the maximum period if:

- any required premium is not paid in full on time,
- a qualified beneficiary first becomes covered, after electing continuation coverage, under another group health plan that does not impose any preexisting condition exclusion for a preexisting condition of the qualified beneficiary,
- a qualified beneficiary first becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage, or
- the employer ceases to provide any group health plan for its employees.

Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

How can you extend the length of COBRA continuation coverage?

If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify the EUTF of a disability or a second qualifying event in order to extend the period of continuation

coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

Disability

An 11-month extension of coverage may be available if any of the qualified beneficiaries is determined under the Social Security Act (SSA) to be disabled. The disability has to have started at some time on or before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined to no longer be disabled under the SSA, you must notify the Plan of that fact within 30 days after that determination.

You must provide the EUTF with notice of the Social Security Administration's disability determination within 60 days after the latest of

- the date of the Social Security Administration's disability determination;
- the date of the covered employee's termination of employment or reduction in hours of employment; or
- the date on which the qualified beneficiary loses (or would lose) coverage under the Plan as a result of the covered employee's termination of employment or reduction in hours of employment.

In addition, in order to be entitled to the disability extension you must provide the EUTF with notice of the Social Security Administration's disability determination within 18 months after the covered employee's termination of employment or reduction in hours of employment. If you provide notice to the EUTF of the Social Security Administration's disability determination at a date more than 18 months after the covered employee's termination of employment or reduction in hours of employment, you will not be entitled to the disability extension, even if you provided the notice within 60 days after receiving the Social Security Administration's disability determination.

<u>You must provide notice of the disability determination in writing. Oral notice, including notice by telephone, fax, or email is not acceptable. If you do not adhere to these instructions or if you fail to provide such written notice to the EUTF within the 60 day notice period described above, you and any other qualified beneficiaries will NOT be entitled to the disability extension of COBRA continuation coverage.</u>

Second Qualifying Event

An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered employee, divorce or legal separation from the covered employee, the covered employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. You must notify the Plan within 60 days after a second qualifying event occurs if you want to extend your continuation coverage.

How can you elect COBRA continuation coverage?

To elect continuation coverage, you must complete the Election Form and furnish it according to the directions on the form. Each qualified beneficiary has a separate right to elect continuation coverage. For example, the employee's spouse may elect continuation coverage even if the employee does not. Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent children. The employee or the employee's spouse can elect continuation coverage on behalf of all of the qualified beneficiaries.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under Federal law. First, you can lose the right to avoid having preexisting condition exclusions applied to you by other group health plans if you have a 63-day gap in health coverage, and election of continuation coverage may help prevent such a gap. Second, you will lose the guaranteed right to purchase individual health coverage that does not impose a preexisting condition exclusion if you do not elect continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under Federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

How much does COBRA continuation coverage cost?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of continuation coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage. The required payment for each continuation coverage period for each option is described in this notice.

The American Recovery and Reinvestment Act of 2009 (ARRA), as amended by the Department of Defense Appropriations Act, 2010, reduces the COBRA premium in some cases. The premium reduction is available to certain individuals who experience a qualifying event relating to COBRA continuation coverage that is an involuntary termination of employment during the period beginning with September 1, 2008 and ending with February 28, 2010. If you qualify for the premium reduction, you need only pay 35 percent of the COBRA premium otherwise due to the plan. This premium reduction is available for up to 15 months. If your COBRA continuation coverage lasts for more than 15 months, you will have to pay the full amount to continue your COBRA continuation coverage. See the attached "Summary of the COBRA Premium Reduction Provisions under ARRA, as Amended" for more details, restrictions, and obligations as well as the form necessary to establish eligibility.

When and how must payment for COBRA continuation coverage be made?

First payment for continuation coverage

If you elect continuation coverage, do not send any payment with the Election Form. You must make your first payment for continuation coverage not later than 45 days after the date of your election directly to the insurance carrier. (This is the date the Election Notice is post-marked) **If you do not make your first payment for continuation coverage in full not later than 45 days after the date of your election, you will lose all continuation coverage rights under the Plan.** You are responsible for making sure that the amount of your first payment is correct. You may contact the appropriate insurance carrier to confirm the correct amount of your first payment or to discuss payment issues related to the ARRA premium reduction. COBRA rates are also accessible on EUTF's website at www.eutf.hawaii.gov.

Periodic payments for continuation coverage

After you make your first payment for continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The amount due for each coverage period for each qualified beneficiary is your responsibility to manage. The Plan will not send periodic notices of payments due for these coverage periods. Payments must be coordinated between you and the appropriate insurance carrier(s).

Grace periods for periodic payments

Although periodic payments are due on the first day of the coverage month, you will be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, your coverage under the Plan will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the periodic payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

<u>If you fail to make a periodic payment before the end of the grace period for that coverage period, you will lose all rights to continuation coverage under the Plan</u>.

However, the Department of Defense Appropriations Act, 2010 provides an extended grace period for certain periods of coverage. If you have reached the end of the reduced premium period, you can make a retroactive payment of the reduced premium(s) for the period(s) of coverage immediately following what would have been the last period subject to the premium reduction. This payment must be made by the later of February 17, 2010, 30 days from the date this notice was provided to you, or by the end of the otherwise applicable payment grace period.

Your first payment and all periodic payments for continuation coverage should be sent to the appropriate insurance carrier(s). The list included below is subject to change. Please contact the carrier directly for billing assistance and to confirm their mailing address.

ChiroPlan Hawaii, Inc. 808-621-4774, 1-800-414-8845
711 Kilani Avenue #3, Wahiawa, HI 96786

Hawaii Dental Service (HDS) 808-529-9285, 1-866-702-3883
700 Bishop Street, Suite 700, Honolulu, HI 96813

Health Management Associates (HMA) 808-951-4621
1440 Kapiolani Boulevard, Suite 1020, Attn: Enrollment, Honolulu, HI 96814

Hawaii Medical Services Association (HMSA) 808-948-6140, 1-800-782-4672
P.O. Box 860, Attn: Membership Services Dept., Honolulu 96808-0860

Kaiser Permanente (Kaiser) 808-432-5955, 1-800-966-5955
711 Kapiolani Boulevard, Honolulu, HI 96813

informedRx [billing handled by ARM Ltd.] 1-800-392-1770
ARM Ltd., 171 West Wing Street #210, Arlington Heights, IL 60005

Royal State National Insurance Company (RSN) 808-539-1600, 1-800-892-9022
819 S. Beretania Street, Honolulu, HI 96813

Vision Service Plan (VSP) 1-800-400-4569 select #2
P.O. Box 997100, Sacramento, CA 95899

For more information

This notice does not fully describe COBRA continuation coverage or other rights under the Plan. More information about COBRA continuation coverage and your rights under the Plan is available in the applicable Reference Guide and in the "COBRA Notice" both of which are available online by visiting EUTF's website at www.eutf.hawaii.gov. Copies of these documents are also available at the EUTF at 201 Merchant Street, Suite 1520, Honolulu, Hawaii 96813.

If you have any questions concerning the information in this notice, your rights to coverage, or if you want a copy of the Reference Guide, you may contact the EUTF at (808) 586-7390 or Toll Free at 1 (800) 295-0089.

For more information about your rights under COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) at 1-866-444-3272 or visit the EBSA website at www.dol.gov/ebsa. State and local government employees should contact HHS-CMS at www.cms.hhs.gov/COBRAContinuationofCov/ or NewCobraRights@cms.hhs.gov.

Keep Your Plan Informed of Address Changes

In order to protect your and your family's rights, you should keep the EUTF informed of any changes in your address and the addresses of family members. Submit any address changes in writing. You should also keep a copy, for your records, of any notices or correspondence you send to the EUTF.

Use this form to notify the EUTF that you are eligible for other group health plan coverage or Medicare and therefore not eligible for reduced premiums under ARRA.

Hawaii Employer-Union Health Benefits Trust Fund	**Participant Notification**	P.O. Box 2121 Honolulu, Hawaii 96805

PERSONAL INFORMATION

Name and mailing address	Telephone number
	E-mail address (optional)

PREMIUM REDUCTION INELIGIBILITY INFORMATION – Check one

I am eligible for coverage under another group health plan. If any dependents are also eligible, include their names below. Insert date you became eligible_____	☐
I am eligible for Medicare. Insert date you became eligible_____	☐

IMPORTANT

If you fail to notify the EUTF of becoming eligible for other group health plan coverage or Medicare AND continue to pay reduced COBRA premiums you could be subject to a fine of 110% of the amount of the premium reduction.

Eligibility is determined regardless of whether you take or decline the other coverage.

However, eligibility for coverage does not include any time spent in a waiting period.

To the best of my knowledge and belief all of the answers I have provided on this Form are true and correct.

Signature → _____ Date → _____

Type or print name → _____

If you are eligible for coverage under another group health plan and that plan covers dependents you must also list their names here:

_____ _____

_____ _____

To apply for ARRA Premium Reduction, complete this form and return it to the EUTF along with your COBRA Election Form.

You may also send this form in separately. If you choose to do so, send the completed "Request for Treatment as an Assistance Eligible Individual" to the EUTF at P.O. Box 2121, Honolulu, Hawaii 96805-2121

Be sure to read the important information about your rights and responsibilities included in the "Summary of the COBRA Premium Reduction Provisions Under ARRA, as Amended."

Hawaii Employer-Union Health Benefits Trust Fund	**REQUEST FOR TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL**	P. O. Box 2121 Honolulu, Hawaii 96805

PERSONAL INFORMATION

Name and mailing address of employee (list any dependents on the back of this form)	Telephone number
	E-mail address (optional)

To qualify, you must be able to check 'Yes' for all statements.

1. The loss of employment was involuntary.	☐ Yes ☐ No
2. The loss of employment occurred at some point on or after September 1, 2008 and on or before February 28, 2010.	☐ Yes ☐ No
3. I elected (or am electing) COBRA continuation coverage.	☐ Yes ☐ No
4. I am NOT eligible for other group health plan coverage (or I was not eligible for other group health plan coverage during the period for which I am claiming a reduced premium).	☐ Yes ☐ No
5. I am NOT eligible for Medicare (or I was not eligible for Medicare during the period for which I am claiming a reduced premium).	☐ Yes ☐ No

I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature → _____ Date → _____

Type or print name → _____ Relationship to employee → _____

FOR EMPLOYER USE ONLY

This application is: ☐ Approved ☐ Denied ☐ Approved for some/denied for others (explain in #4 below)
Specify reason below and then return a copy of this form to the EUTF.

REASON FOR DENIAL OF TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL

1. Loss of employment was voluntary.	☐
2. The involuntary loss did not occur between September 1, 2008 and February 28, 2010.	☐
3. Individual did not elect COBRA coverage.	☐
4. Other (please explain)	☐

Signature of employer:

→ _____ Date → _____

Type or print name → _____

Telephone number → _____ Position Title → _____

DEPENDENT INFORMATION (Parent or guardian should sign for minor children.)

Name Date of Birth Relationship to Employee SSN (or other identifier)

a. _____

1. I elected (or am electing) COBRA continuation coverage.	☐ Yes☐ No
2. I am NOT eligible for other group health plan coverage.	☐ Yes☐ No
3. I am NOT eligible for Medicare.	☐ Yes☐ No

I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature → _____ Date → _____

Type or print name → _____ Relationship to employee → _____

Name Date of Birth Relationship to Employee SSN (or other identifier)

b. _____

1. I elected (or am electing) COBRA continuation coverage.	☐ Yes☐ No
2. I am NOT eligible for other group health plan coverage.	☐ Yes☐ No
3. I am NOT eligible for Medicare.	☐ Yes☐ No

I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature → _____ Date → _____

Type or print name → _____ Relationship to employee → _____

Name Date of Birth Relationship to Employee SSN (or other identifier)

c. _____

1. I elected (or am electing) COBRA continuation coverage.	☐ Yes☐ No
2. I am NOT eligible for other group health plan coverage.	☐ Yes☐ No
3. I am NOT eligible for Medicare.	☐ Yes☐ No

I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature → _____ Date → _____

Type or print name → _____ Relationship to employee → _____

NOTE: If there are more dependents that must be included for coverage, please make a copy of this page and attach it to your submission. Thank you.